VOL. 15, NO. 5 JAN.-FEB., 1966

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

TREATMENT

REHABILITATION

EDUCATION

PREVENTION

N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

About the Center . . .

The A.R.C., as it has come to be known, is a 50 bed in-residence treatment facility for problem drinkers. Located at Butner, N. C., a small community approximately 12 miles north of Durham, N. C. off Highway 15, it is operated under the authority of the N. C. Department of Mental Health. The Center provides residence, treatment and workshop facilities for 38 male and 12 female patients.

A.R.C. Treatment Methods . . .

Treatment is by psychotherapy and consists of group discussions led by the professional staff, educational films, individual consultations with staff members, vocational guidance, recreation, rest, proper food and prescribed medications.

Length of Stay . . .

The basic treatment program is based on a 28-day schedule. The patient may remain for a longer period if, in the opinion of the staff, it will be of further therapeutic benefit to him. No applications for less than 28 days are accepted.

Admission Requirements . . .

1. Persons desiring admission must come voluntarily. No one can be admitted by court order. The individual who is sincere in wanting help and who comes voluntarily stands a much better chance of successful rehabilitation.

2. An appointment for admission is obtained by written or telephone application to the Admitting Officer, 406 Central Ave., Butner, N. C. (telephone 919 985-6770). All appointments are confirmed by mail. Preferably they should be made through a physician or other professional person in the prospective patient's community.

3. Since the Center is not designed, nor equipped, as a sobering up facility, the prospective patient must not have taken any alcoholic beverages for at least 72 hours prior to admission.

4. A report of a recent physicial examination by a duly licensed physician must be presented prior to or at the time of admission. The prospective patient's physical condition must be reasonably good enough to enable him to participate fully in all phases of the treatment program. There are no medical beds for the treatment of serious physical or mental disorders.

5. A fee of $75 in cash or certified check only must be paid at the time of admission. No personal checks can be accepted! Cases of true indigency must present written evidence in the form of a letter from their county welfare department at the time of admission or before.

6. A social history, compiled by a trained social worker in the local welfare or family service agency or other professional organization is required. Arrangements for the history should be made early enough so that it reaches the Center within a week following admission.

Admitting Days . . .

In order to facilitate the program of treatment by the small group method, prospective patients are admitted on Wednesdays, Thursdays and Fridays from 8 to 12 a.m. and 1 to 5 p.m. In this manner several days of adjustment to the life of the Center are provided before the beginning of the intensive treatment program the following Monday.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA DEPARTMENT OF MENTAL HEALTH

NORBERT L. KELLY, Ph.D.
Associate Director

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In language anyone can understand a pastor illustrates with homespun stories a philosophical basis for helping an alcoholic.

How to Help the Alcoholic and His Family

BY PASTOR THOMAS J. SHIPP

—From *Listen* as published in the *Magazine* of the Temperance Union, Johannesburg, S. A. R., in the September-October issue, 1965. Reprinted by permission, *Listen* is published by the American Temperance Society, 6840 Eastern Ave., N. W., Washington, D. C., 20012.

WHEN I was very young I thought a desert was barren because of a lack of fertility in the soil itself. Later I had the privilege of living on a desert, and it didn't take long to discover that this was far from true. It is not lack of fertility in the soil that makes the desert barren, but the drift of the sands. This drift cuts away life, and leaves no opportunity for vegetation to grow. The way to combat this problem is to set up a barrier to stop the drift of the sands. If this is done you will soon see new life begin to take hold—as though by magic.

By the same token, the alcoholic's life is not barren and unfruitful because the man himself is no good, but rather because of the pattern in which his life has drifted. We find that the first help that must be given the alcoholic is to set up barriers that will help to stop the drift of his life—a life that has taken on the appearance of being barren and worthless.

Before the alcoholic will let anyone help him put up these barriers, he must have confidence and trust in the person wishing to help.

How may this be accomplished? How may you avoid the mistakes that have been made in this regard in the past?

In the first place, both the clergy and the layman have been over-critical. We have been quick to pass judgment and to push the alcoholic down with a "no good" label, pointing our long finger at him as though he were an outcast. Should the average congregation find out that a certain individual was an alcoholic, they would immediately pass moral judgment and become unkind, impatient, and intolerant, rather than understanding and helpful.

One must remember that no man can actually be helped by pointing

out his wrongs. Practically anyone with average intelligence is well aware of the things he is doing wrong. How well I recall a young baseball player who was on his way to the top, when he hit a slump and could do nothing right. One day during batting practice he asked his coach, "Tell me what I am doing wrong." "I wouldn't for anything in the world," he answered.

"Why?" asked the ballplayer. The coach replied, "If I tell you what you are doing wrong it will be hard for you to forget the wrong. But I'll be glad to point out the right things you are doing, and we'll sharpen them up until they outweigh the wrongs." Pointing out another person's wrong does us more good than the person we are trying to help. This is even more true with the alcoholic.

He knows all his shortcomings. He doesn't have to be forewarned of the pending loss of his self-respect, his job, his home, and everything he has. He knows these things far better than you; this may even be the reason he is drinking. He doesn't need a soothsayer to tell him what is going to happen; rather he needs a friend to point a way of hope and give him some idea what he might be able to do to straighten out the remainder of his life—in other words, someone to help him find a better way of life.

The second thing to remember in helping people is that you can't help them by ignoring them. Yet this is exactly what we have attempted to do many times in the church. When we discover a person is an alcoholic, we avoid him, ignore him, push him out, and then sit back and wonder why we haven't helped him. We isolate him from our fellowship, make him feel unwelcome, and then have been puzzled as to why we have lost him. You who are married know that you did not fall in love with your wife by ignoring her, you fell for her by giving her your best attention. Take your best friend, ignore him time after time and see how long he will remain active in your fellowship. Yet this is what we have done with the alcoholic.

Let me illustrate what I mean: When I was a boy I lived on a farm, and a neighbor gave me a very fine pedigreed Persian cat, complete with papers. On the same day I received the gift I happened to find an old alley cat in the lot behind the barn. Apparently he had been tossed out of a passing car. This particular cat had many fine points, too, because you could see them all through the skin. I made friends with him and nursed him as he slowly regained his health.

The interesting comparison between these two cats is that the fine Persian was never a very good pet, while the mongrel became one of the staunchest friends I have ever had. At first I thought it was a difference in the two animals, but I soon figured out that it was not that at all. Both cats could be sitting on the back steps when I left the house. Within seconds the Persian would be nowhere to be seen, while the alley cat would hang on my heels and follow every step I took. The reason for this was not a fundamental difference in the cats, but rather a difference that was formulated by my actions toward each of them. I had noticed one of them, I had given him attention, I had shown concern. The other cat I had ignored, paid no attention to, given him no love, and even turned my back on him, in the interest of the stray.

Third, if you are going to help the alcoholic, you must recognize that there is a difference in building a

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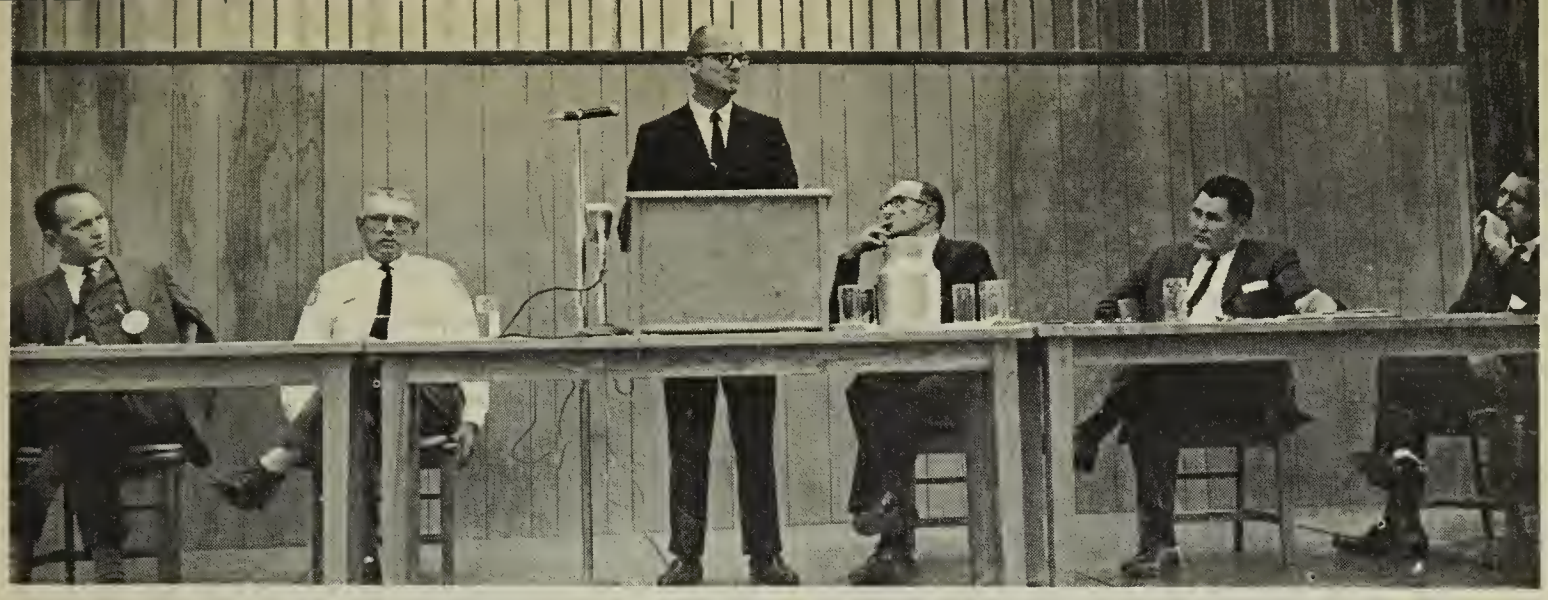
EDITOR'S NOTE: Your sober (no pun intended) attention is directed to the articles in this issue pertaining to the pros and cons of jailing alcoholics and the question of the constitutionality thereof.

As we went to press, the ruling of the U. S. 4th Circuit Court of Appeals on January 22 (excerpts of which appear on the opposite page) may have made some of the discussions and opinions expressed irrelevant. However, they are still offered as background information and samples of representative current thinking and practice.

Regardless of one's own position in or feeling about the controversy of "to jail or not to jail," the ruling of the Court has not, will not, and can not, solve the problem of the "chronic drunkenness offender." The problem remains to be solved within the confines of the law through creative thinking, planning, and action on the part of concerned communities and citizens throughout the U. S.

ESTIMATED NUMBER OF ALCOHOLICS: The National Council on Alcoholism has announced its intention of settling on the figure of 6,500,000 as the best available estimate of the number of alcoholics in the United States. This figure is also being used by a number of state programs, apparently as a reasonable compromise to various other estimates. Current estimates have ranged from a high of 9,500,000 (New York State Journal of Medicine, 1964) to a low of 4,470,000 (Mark Keller, 1962, editor of the Quarterly Journal of Studies on Alcohol, writing in **Society, Culture, and Drinking Patterns,** Pittman & Snyder). The 6,500,000 figure may be derived at by projecting to 1965 the average per year increase of the Jellinek formula based on the years 1944 through 1956. It also approximates the figure of 6,120,000 based on the Jellinek formula as applied by University of Utah statisticians.



Scene from a 1965 meeting of the Alcoholism Programs of North Carolina.

BUTNER, N. C.: "Taking Our Inventory" will be the theme of the joint workshop on alcoholism of the N. C. Department of Mental Health and the Alcoholism Programs of North Carolina to be conducted February 24 at the Vocational Rehabilitation Building of John Umstead Hospital. Topics to be discussed at the workshop include: Regional Alcoholic Rehabilitation Centers, Admission Policies, Training and Research, and Community Programs of Education, Information and Treatment. The workshop will begin at 9:00 A.M. and conclude at 4:00 P.M. with a wrap-up and general sharing session.

DISEASE IS NOT CRIMINAL: (The following are excerpts from the decision of Circuit Judge Albert V. Bryan, Fourth Circuit Court of Appeals, Richmond, Va., as published in the News and Observer on January 30, 1966.)

A new legal approach to the chronic alcoholic arises from the decision of Circuit Judge Albert V. Bryan, Fourth District Court of Appeals, in the case of Joe B. Driver of Durham. Driver is an admitted alcoholic and has been imprisoned under North Carolina Statute for public drunkenness.

The question is whether a chronic alcoholic, as appellant Joe B. Driver has been proved and confesses to be, can constitutionally be criminally convicted and sentenced, as he was, for public drunkenness.

Admitting the truth of the charge under the North Carolina statute, he grounded his defense on the Eighth Amendment, applied to the states under the due process clause of the Fourteenth, barring the infliction of "cruel and unusual" punishment.

The argument may be condensed in this syllogism: Driver's chronic alcoholism is a disease which has destroyed the power of his will to resist the constant, excessive consumption of alcohol; his appearance in public in that condition is not his volition, but a compulsion symptomatic of the disease; and to stigmatize him as a criminal for this act is cruel and unusual punishment.

This plea failed in the State courts. (State v. Driver, 262 NC 92, 136 SE2d, 208, 1964). Thereupon he unsuccessfully petitioned the Federal district court for habeas corpus to procure release from imprisonment ordered on his sentence. From this denial he appealed.

We find merit in his petition. Accordingly we must vacate the judgment on review and remand for further proceedings . . .

Driver was 59 years old. His first conviction for public intoxication occurred at 24. Since then he has been convicted of this offense more than 200 times. For nearly two-thirds of his life he has been incarcerated for these infractions.

Thus the question here is beyond the difficult determination of whether

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life and in rebuilding one. There is a great deal of difference in building a new house and in remodeling an old one. If you are going to build a new home, you can draw your plans and construct the house the way you wish. But if you are going to remodel a house, there are many factors which must be taken into consideration, and you must work with that which has already been constructed. You may find walls in places that you do not desire, but before you begin to knock out those walls, you must find out what they may be holding up. If you should knock out certain walls, the whole house may collapse on you.

The same is true with the alcoholic. Before you start to remove certain things from within his life, you had better find out why they are there, and what meaning they have to him. Many people have the idea that if you remove the alcohol from the alcoholic you have solved his problem. This is far from true. In working with the alcoholic this is one of the hardest lessons to learn.

Another thing we must remember, before we remove a wall that is helping to hold up the structure of the house, is that we must put something in its place. This is one of the reasons why I feel that Alcoholics Anonymous has been so successful. It has done more than merely remove the alcohol; it has replaced it with a programme of life that gives support and strength. I feel that this is the grave mistake which has been made by the church. We have said to the alcoholic, "Quit drinking, straighten up, and everything will be all right." But we have failed to put something back to fill the void which has been left by the removal of alcohol. If you remove alcohol from the alcoholic and do not replace it with something constructive, you may find that you have done an injustice and he may end up with many more problems than those which he had while drinking.

The fourth thing I would like to call to your attention is that, after you have removed something old and replaced it with a new way of life, you must remain close to the alcoholic until he becomes adjusted to the new. When you remodel a house, it takes time for one to adjust to the reconstruction.

If there is any one thing that is difficult for the alcoholic, it is to change or to turn loose of something that he has been used to, and he needs a certain amount of support and encouragement until it becomes a part of his life.

I remember an incident that happened many years ago while I was on the farm. A young man was working his father's farm which was next to ours. One day the father decided to make things easier for his son by giving him a new tractor and a cultivator. He spent an afternoon with the boy plowing corn. The next day the father returned to find his son using a team of mules and a horsedrawn cultivator. He was angry, and snapped at the boy, "Why aren't you using the new tractor? You are wasting my time, you are wasting your time, and you could be doing a much better job with the tractor than with that team of mules."

The lad looked his father in the eye and replied, "Dad, when you give a man a piece of equipment, you had better stay with him long enough to be sure he knows how it use it, or he may plow up more corn and do more damage than he will good."

The same thing is true with the alcoholic. We must stay with him in this new way of life until he finds how to use it and how to live with it.

Point number five: How do you

get alcohol away from an alcoholic and how do you get him to give it up? This was one of the hardest lessons I had to learn in working with the alcoholic, because I soon found out that you do not take alcohol away from him. You do not ask him to give it up. It has been years since I actually asked a person to quit drinking. My son really taught me an important lesson along these lines when he was about five years old. I was watching him play with another youngster one day. They were in a sandbox, and it happened that his playmate had something that my son wanted. He tried to take it by force, and when the other youngster put up a fuss, their relationship suddenly became very strained.

Changed Approach

A few minutes later my son tried another approach. He found another toy and started playing with it near his little friend, showing a great deal of interest in it. Pretty soon the other lad reached over and took it and left the first toy alone. This proved to me that the easiest way to get something away from a child is not to grab it away or try to take it by force, or your relationship will be strained. However, if you give the child something else to interest him, you will find it easy to remove the other from him.

Adults are not much different, and this is especially true of the alcoholic. Do not take away his drink, but offer him something better. When you are able to offer the alcoholic a way of life that will meet his needs, you will find it much easier to remove the alcohol.

When I was in college I worked for a builder. We were going to replace the piers under a house. The old wooden piers were becoming weak and needed to be replaced. We went under the house and put new piers all the way round, then one of us asked the builder, "Do you want the old ones removed?" He replied, "No, that would be a waste of time, let the house settle down on the new piers and when they carry the weight and the load of the house, then the old piers will fall away and it will not be difficult to remove them."

When you replace the old with something new in a life, and that life becomes dependent on the new, it will not be long until the old will fall away.

In the sixth place, if you are going to help the alcoholic you must be willing to go the second mile, to do the unexpected. Jesus said, in effect, "If a man ask you to go one mile, go with him two. Give when you are asked to give and do not turn your back." See Matthew 5:41,42.

In working with the alcoholic I have often found that it is the unexpected and a bit of extra help that wins him. Just one tip that I have found to be helpful when I first start working with an alcoholic: If he has just gotten off alcohol I will ask what is the roughest time of the night for him. It may be 3:00, 4:00, or 5:00 in the morning. I will set my alarm for that hour occasionally, and call him. When I reach him I will often say, "I know this is a rough time and I just happened to be awake and wanted to call you and let you know that I was thinking of you. You are not alone in this fight; I am pulling for you tonight and I know you can make it."

In many cases this is all that it will take to get him through the night without a drink.

Finally, I would say, if you just sober a man up and you have not led him to God, and you have not given him a new way of life, you have done little or nothing for him.

In Doctor's Office

I read *Inventory* in my doctor's office and would like to receive it since I have an alcoholic problem.

Anonymous
Raleigh, N. C.

Editor's Note: The suggestion that alcoholism be renamed "Jellinek's disease" made by Michael Shenkman, M.D. in "Alcoholism Revised" which was published in the May-June, 1965, Inventory stirred up quite a bit of interest and provoked a good deal of thought. We think he is entitled to this rebuttal in response to a later article "A New Name for Alcoholism" by Ashton Brisolara which was published in the September-October, 1965, Inventory.

Rebuttal

Ashton Brisolara, executive director of the Committee on Alcoholism for Greater New Orleans, in his article, "A New Name for Alcoholism?," refuted my suggestion of renaming alcoholism "Jellinek's disease" made in a previous article.

I want to thank Mr. Brisolara for reinforcing very strongly my concept or belief that alcoholism as a label should be erased and replaced with Jellinek's disease. By enumerating the "whys" of his point of view, he inadvertently reinforced the "whys" of mine. Let me explain.

Mr. Brisolara said among other things that "changing the term would only tend to hide the symptoms which make the illness recognizable." Well, are the symptoms recognizable in established and accepted pathological conditions such as Graves disease, Cushing's syndrome, Fallot's tetralogy and many, many others? Of course not. Physicians all have to learn the contents of a given label and use it accordingly.

The tragedy of the so-called alcoholism label is that it is not understood nor accepted by the community at large. Neither is it understood or accepted by a great majority of our professional community. As is well-known the use of it invokes so much stigma, so much prejudice and injustice that, and I quote Mr. Brisolara verbatim, "Alcoholism is not as yet generally accepted as an illness. Few hospitals accept alcoholics under the diagnosis of alcoholism. Few doctors treat alcoholics. Many religious denominations oppose the disease concept of alcoholism. Employment applications discriminate against the the alcoholic by denying him employment. Alcoholics are hidden by families."

I wholeheartedly agree with all these statements but, Mr. Brisolara, let us erase and forget the awful term which perpetrates these evils. Let us use, instead, the name of one who gave so much in the field of alcoholism—Jellinek. And when doctors learn the contents of, and start to use, the label of Jellinek's disease, the community at large will "catch on" and a new era in the field of alcoholic rehabilitation will start. All the evils that Mr. Brisolara enumerated will gradually fade away.

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VOL. 15, NO. 5 INVENTORY JAN.-FEB., 1966

ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

The physician's reactions to alcoholism largely reflect society's attitudes rather than basic scientific knowledge.

In Alcoholism

The Soma & The Psyche

ALCOHOLISM has been described as "the" psychosomatic illness of our day. The first half of the word, psychosomatic, means soul or mind; the latter half, the body. This is not news to those of you who are physicians. However, most doctors who treat alcoholism treat the soma and ignore the psyche. This process not only fails miserably to treat the underlying illness of the psyche, it may aid and abet the progress of the underlying illness and thereby aid and abet the alcoholism.

As a minister, I know this from actual experience. I saw five persons in one of my former parishes die from chronic and acute alcoholism in a period of five years. All of them received the finest medical attention often administered in hospitals which do not admit alcoholics in a normal routine procedure. The doctors lost their patients and I lost my parishioners because I failed to deal with their psyche and they were treating only the after effects of the symptom of alcoholism—drunkenness.

Alcohol has been described as "man's psychological blessing and physiological curse" by Dr. Norman Desrosiers, a former medical director of the Alcoholic Rehabilitation Center at Butner, N. C. The trouble is that the patient with alcoholism can bless himself more rapidly and thoroughly than the doctor can remove the curse. One reason he can do this is because we live in a society which is completely ambivalent in regard to the use of alcohol.

The majority of the people in our community, for instance, consider it wrong to take a drink, yet there is extreme permissiveness of drunkenness—unless, of course, it happens to take place publicly, especially in the downtown area.

Correcting this ambivalent attitude of which physicians are a part would do much to prevent alcoholism and

BY REV. JOSEPH L. KELLERMANN

This article is based on a talk given by the author before the Mecklenburg County Medical Society in September, 1965. Rev. Kellermann, director of the Charlotte Council on Alcoholism, is noted as an ardent advocate of "family treatment" in alcoholism. "Without treatment and counsel for the family," he says, "the alcoholic will continue to dominate the family and thereby postpone seeking adequate help in recovery."

open the door to a more adequate approach to the illness. The classical position of the Bible and the historic church is needed in this area, that of temperance, which means permissive use combined with rigid discipline against any excessive use or abuse of alcohol.

The first step, then, in treating alcoholism is to create a consistent attitude toward alcohol.

The Charlotte Council on Alcoholism which came into existence as a voluntary health agency in 1958 to this end renders services in four pertinent areas: education, operation of an information center, treatment and research.

It has three areas of interest in education: public school education, professional education and general public education.

Every state in the nation requires by law that its schools teach the subject of alcohol, yet few schools have adequate alcohol education programs and few persons graduate from our school systems with any basic, scientific knowledge in this field. School text books do not include adequate material and teachers lack special training. The goal is not to do the teaching but to assist the schools in the development of an adequate alcohol education program.

This address is an example of professional education. It is not an after dinner speech. I am talking about an incurable chronic illness which may be arrested but gets progressively worse if the patient continues to drink and reduces the patient's life expectancy to about 52 years. Most persons in the helping professions, including ministers, doctors and lawyers, are woefully unprepared to cope with alcoholism. Having failed to receive adequate education in public school and college, few professional persons learn much in graduate school about alcohol and alcoholism from an objective point of view although I understand many medical students have attempted to learn by subjective experience. However, this experience is worthless in treating a patient unless you are the patient and if so I can predict that your medication will be excessive use of alcohol. Alcoholics don't drink, they medicate, and what person has a better opportunity of concealing this fact than a physician.

The council, by printed literature, public addresses, conferences, workshops, etc., by press, radio and television, attempts to reach the general public because unless we change the image of the alcoholic in the mind of the public we can not treat the patient.

In summary, public school education is for those persons who are growing up and general public education is for those persons who have "growed" but are not "up" on the subject of alcoholism. As pros physicians need special training of which this address is a tiny part.

The second area of our work is the operation of an information center. The Alcoholism Information Center is the council's office, headquarters, planning center. Any person may write, phone or visit the office for information in regard to self, family, client or patient. However, the center does not exist primarily for the alcoholic, but to assist the family of the alcoholic and professional persons who serve the family and the alcoholic. It exists to inform the community about alcoholism, not to whisper some secret and magical formula for sobriety into the ears of some chronic alcoholic. Professional referrals are welcome, especially from the boss or the company doctor. Send us the wife and the boss of the alcoholic for infor-

mation and counsel and if we can reach an understanding and agreement I will give you a prognosis that up to 90 per cent of the patients will recover. If you send the patient and leave out the wife and the boss I will give you a prognosis that less than 10 per cent of your patients will recover.

Medically, we do no work in the area of treatment. As a voluntary health agency, our task is to encourage the community and state to create adequate treatment facilities and to assist families in securing adequate treatment for themselves and the patient. Often the key factor in this area is helping the family understand how to motivate the patient to seek help instead of assisting the patient in his escape mechanism of alcoholism.

Fourth Area of Interest

Basically research, our fourth area of interest, is carried on by specialists although at times we play a small part. Last year we participated in a study which looked into the question of whether or not there is a relationship between the type of sale of alcoholic beverage and the problems related to its use. Five types of sales were examined, ours being that of the A.B.C. monopoly with county option basis. Our report was described as the most complete of the nine cities surveyed—three in New York, two each in New Jersey and Pennsylvania and the other in Virginia. The study revealed what was already general knowledge by those working professionally in the field, that there is little, if any, relationship between the type of sale of alcohol and the problems which arise out of its use—so long as control of the sale is exercised. During the recent hubbub over the so-called "open bar" question the press enjoyed the news value of the controversy but was totally disinterested in presenting an analysis of the study, copies of which we made available.

Enough has been discovered today by alcoholism research to make a real difference in this problem. However, even though people clamor for the latest knowledge of any form of treatment of dread diseases, getting basic knowledge of research studies to the general public in this area is extremely difficult because channels of communication are still largely controlled by those who are misinformed.

The best series of articles I have ever written for the press was rejected, for instance, because it was declared to be "too clinical." The last reject I had from one of my own church magazines termed a simple direct description of the earliest symptoms of alcoholism as "inappropriate."

The fanaticism of the ardent prohibitionist and abstinence worker is completely overshadowed by the passive hostility of the overly permissive majority of our population which violently resists coming to grips with the role of alcohol and alcoholism in our culture. Most physicians' ideas about alcoholism are colored by this cultural vacuum and ambivalence as to the use of alcohol and the illness of alcoholism. As one who consistently insists that temperance, not abstinence, is the Christian virtue, I am convinced that a consistent, scientific attitude on the part of physicians toward the use of alcohol and toward the social treatment of the alcoholic would do far more to reduce alcoholism than all the medical facilities you could provide without attitude changes.

The increased incidence of alcoholism is outrunning the increase in treatment facilities. Medically speak-

ing the goal is prevention—if possible—and next early detection and treatment. In alcoholism we are indifferent to prevention, completely timid and cowardly about early detection and treatment, and adequate care and treatment is provided for less than 10 percent of today's chronic alcoholics. Alcoholism is the largest single admission classification to our state mental hospitals, yet at Broughton Hospital in Morganton—which serves our section of the state—less than 3 per cent of the beds are allotted for alcoholism treatment and committed patients sometimes wait two weeks for admission after judicial action has been taken.

However, the lack of medical facilities is not the basic problem in the area of alcoholism as it relates to medical practice. As Dr. Tommy Jones has repeatedly pointed out, "A boy scout with a bottle of aspirin and a pup tent could provide better treatment for the alcoholic than the best doctor with the finest hospital facilities whose attitude was one of hostility and rejection." The attitude of the doctor and his knowledge of the illness as a social disorder is far more important than the physiotherapy he administers.

I know of one patient who was hospitalized 63 times in less than 10 years as a result of acute intoxication. On 62 occasions his life was saved; the 63rd was unsuccessful. Experiences of this kind tend to give an impression that alcoholism treatment is a rather futile practice of medicine. I will now dare suggest that the general medical treatment which the alcoholic receives today, even though it is completely within the area of medical ethics, would in most cases fit into a classification of social irresponsibility. In this irresponsibility the patient, the family, the doctor and the minister are

We must treat the psyche—

equally guilty.

The alcoholic is sick spiritually, mentally and physicially. If we are to treat this psychosomatic illness we must treat the psyche, the soul and mind of the patient, if we anticipate recovery. The emphasis on the medical aspects of the illness has tended to overshadow the soul sickness which must be treated if the patient is to recover. The toxic effect of alcohol finally changes its psychological blessing into a physiological curse. A physician who treats the patient without getting him into continued therapy after the reduction of acute intoxication is actually being used by the patient in the same way he initially used the bottle—simply as another escape mechanism.

Although there are five major types of alcoholism, the physician primarily sees the nonremittent type which gets progressively worse as the patient continues to drink. The chronology of this patient runs somewhat as follows: The illness can begin in the teens or when a person is 60 or 70 years old; but there is a basic pattern which will include at least 90 per cent of the patients if five years are added or subtracted to the mean age of the following symptomatic appearances. The average American boy starts drinking at 17 and many persons who become alcoholics are drinking excessively within two years. By the age of 30 amnesia or loss of memory of drinking experiences occur. Three or four such experiences is medical proof of the existence of alcoholism. At an average age of 33 the alcoholic loses the ability to abstain of his own will and volition. We call this compulsive drinking. Once the compulsive pattern is established it is essential that

outside help and therapy be secured if this patient is to overcome the compulsion and relearn the capacity to abstain. Morning drinking starts somewhere in the mid-thirties and, by the time the alcoholic reaches 40, addiction or chronic alcoholism appears. At this point sobering up is so painful that the alcoholic seeks the physician's help and—in extreme cases—hospitalization is required.

The point is that the compulsive drinking pattern has been deeply ingrained for an average of at least six years and often much longer before the patient seeks medical help for the first time. No recovery can be anticipated unless the patient is willing to work at his recovery for a period of two or three years which is the length of convalescence of the average chronic alcoholic. To treat the soma without insisting upon long-term treatment of the psyche is to assist in the progress of the disease and invite the untimely death of your patient.

There is a way—which I will attempt at this point to indicate—for the physician to avoid this tragic loss of patient and also save himself time in the long run, although it will take initial time, effort and expenditure of action in the area of moral responsibility.

Industrial programs of alcoholic rehabilitation are providing effective rehabilitation in 60-90 per cent of the patients, depending upon the thoroughness of the industrial occupational health program. Success results from the realization that discipline must be inserted into the treatment process and some person in a position of responsibility must lay down the rules of recovery.

Two persons can motivate the alcoholic to recover and if they team up the success rate can reach 90 per cent. If they are left out of the picture the recovery rate can drop below 10 per cent. These two persons are first the boss and secondly the spouse of the alcoholic. If the man is self-employed the wife or family then becomes the focal point of the treatment process.

Excessive drinking persists if one primary condition is retained in the drinking process. Regardless of what you and I think, the alcoholic is using alcohol as a source of comfort in a continuing successful fashion from his point of view. In plain language the paient is treating himself. If you treat the somatic condition alone you cease being a physician and become a pharmacist and the patient writes the prescription. It is the ingenious capacity of the alcoholic to put the physician in this position that thwarts most of his efforts to treat alcoholism.

Where do we begin if successful treatment is to be administered?

First, we must gain basic knowledge of the three elements that go into this illness: Alcohol, the agent; the emotionally distressed person, the host; and the family and our present social structure, the environment in which this illness is permitted to develop. All three of these elements must be present if the illness is to come into existence and advance.

Alcoholism is never an isolated condition but a learned pattern of excessive use of alcohol by a person. The potential alcoholic drinks. Alcohol meets deep-seated emotional needs but causes serious social disorder. The family and society react. The patient evaluates the reaction.

If the pleasure of alcoholic escape from his psychic pain is greater than the painful consequences of his drinking, he will drink again. No person becomes an alcoholic without the cooperation of his family and society. To try to eliminate the availability of alcohol is not the answer. To treat the patient only may in rare instances bring miraculous recovery, but this is very infrequent. Success in recovery begins when the alcoholic's family changes and there is little chance of success without it.

Your alcoholic patient's chance of recovery is multiplied by 10 if you can get his spouse, parent or, in effect, the entire family engaged in learning about alcoholism and entered into therapy for their own emotional inadequacies.

If you do not have time to confer with the wife and help her understand this principle, it is your responsibility to refer the spouse for such basic counseling as will enable her to understand the nature of the problem and change her approach.

Whoever is next of kin or whatever person is acting as a source of dependency for the alcoholic must change if the patient is to recover. Most of the Charlotte Alcoholism Information Center's clients are members of the families of alcoholics, primarily the wives of alcoholic husbands. When the wife changes drastically we may expect a marked change in the drinking pattern. Sufficient change in the wife alone is enough to result in the recovery of at least half the alcoholic husbands. Dr. John Ewing of the University of North Carolina researched 32 wives of alcoholics he had under individual and/or group therapy. Sixteen husbands recovered; six made good improvement in their drinking pattern; five made fair improvement and only five failed to change.

That which will prevent the return of a mental patient to the hospital is not the quality of therapy, or the condition of the patient at the time of discharge, but the attitude and treatment the patient will receive on a continuing basis when he gets home. The same holds true for the alcoholic. The family must be re-educated, reoriented, and make profound changes in their attitude and approach if your alcoholic patient is to be shielded against a habitual pattern of relapse.

It should interest you to know that wives of physicians are very difficult clients, not because they are different from other women, but because their husbands are physicians and the doctor's wife suffers double jeopardy from shame and stigma. The doctor reacts to this illness just as the layman. He, too, is locked in a phase of resistance to treatment and denies that the illness exists.

A local physician was sending patients and their wives to me for counsel until his wife came to me as a client. He refused to come with her or come alone and stopped making referrals.

Doctors' wives tell me they have extreme difficulty in securing an admission from their husbands of the illness and just as much difficulty as any other spouse in motivating the husband to accept treatment. A doctor whose husband or wife develops alcoholism is just as unrealistic as any other husband or wife. Medical objectivity disappears when a physician or a member of his family becomes alcoholic.

One reason for this is the fact that the medical profession has not developed a consistent attitude toward alcoholism commensurate with knowledge that is now available. The physician's reactions in this area are

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the accused is a chronic alcoholic. Our discussion and decision, it must be recalled throughout, presuppose an indisputable finding that the offender is a "chronic alcoholic."

This addiction—chronic alcoholism—is now almost universally accepted medically as a disease. The symptoms, as already noted, may appear as "disorder of behavior." Obviously, this includes appearances in public, as here, unwilled and ungovernable by the victim.

When that is the conduct for which he is criminally accused, there can be no judgment of criminal conviction passed upon him. To do so would affront the Eighth Amendment, as cruel and unusual punishment in branding him a criminal, irrespective of consequent detention or fine.

Although his misdoing objectively comprises the physical elements of a crime, nevertheless no crime has been perpetrated because the conduct was neither actuated by an evil intent nor accompanied with a consciousness of wrongdoing, indispensable ingredients of a crime.

This conclusion does not contravene the familiar thesis that voluntary drunkenness is no excuse for crime. The chronic alcoholic has not drunk voluntarily, although undoubtedly he did so originally. His excess now derives from disease.

However, our excusal of the chronic alcoholic from criminal prosecution is confined exclusively to those acts on his part which are compulsive as symptomatic of the disease. With respect to other behavior—not characteristic of confirmed chronic alcoholism—he would be judged as would any person not so afflicted.

Of course, the alcohol-diseased may by law be kept out of public sight. Equally true, the North Carolina statute does not punish them solely for drunkenness, but rather for its public demonstration.

But many of the diseased have no homes or friends, family or mean to keep them indoors. Driver examples this pitiable predicament, for he is apparently without money or restraining care.

Robinson v. California (370 US 660, 1962) sustains, if not commands, the view we take. While occupied only with a State statute declaring drug addiction a misdemeanor, the Court in the concurrences and dissents, as well as in the majority opinion, enunciated a doctrine encompassing the present cases . . .

"It is unlikely that any State at this moment in history would attempt to make it a criminal offense for a person to be mentally ill, or a leper, or to be afflicted with a venereal disease. A State might determine that the general health and welfare require that victims of these and other human affictions be dealt with by compulsory treatment, involving quarantine, confinement, or sequestration. But, in the light of contemporary human knowledge, a law which made criminal offense of such a disease would doubtless be universally thought to be an infliction of cruel and unusual punishment in violation of the Eighth and Fourteenth Amendments."

We do not annul the North Carolina statute. It is well within the State's power and right to deter and punish public drunkenness, especially to secure others against its annoyances and intrusions.

To this end any intoxicated person found in the street or other public areas may be taken into custody for inquiry or prosecution. But the Constitution intercedes when on arraignment the accused's helplessness comes to light. Then it is that no criminal conviction may follow.

The upshot of our decision is that the State cannot stamp an unpretending chronic alcoholic as a criminal if his drunken public display is involuntary as the result of disease. However, nothing we have said precludes appropriate detention of him for treatment and rehabilitation so long as he is not marked a criminal.

If It Is Unconstitutional To Jail Alcoholics—What Then?

BY CHARLES Z. SMITH
JUDGE, MUNICIPAL COURT, SEATTLE, WASHINGTON

AT a hearing held during the 1965 session of the Washington State Legislature, this writer declared that it is reasonable to contemplate that the United States Supreme Court will probably rule that it is unconstitutional to punish a person by fine or imprisonment upon conviction of public drunkenness when that drunkenness is due to chronic alcoholism by medical-psychiatric definition.

If the Supreme Court should rule as predicted, the impact of that decision will be significant for all those actively concerned with the problems of alcoholism, either as private citizens or as law enforcement and judicial authorities.

The statement made at that legislative hearing, however, has been misinterpreted by many laymen and even by many lawyers—despite the fact that it is based upon reasoning set forth in a decision by the United States Supreme Court in the case of **Robinson v. California,** June 25, 1962.

Robinson v. California is a case in which the defendant, Robinson, was convicted of violating a California statute on narcotics addiction; but the reasoning behind the Supreme Court's decision is worthy of study by anyone interested in the legal aspects of alcoholism, especially in view of the fact that at least two cases involving conviction of chronic alcoholics should soon be before the court.

Robinson was convicted of being a narcotic addict in the Municipal Court of the City of Los Angeles.

The police officer who testified in the case stated that at the time he examined the defendant he observed "scar tissue and discoloration on the inside" of the defendant's right arm; and "what appeared to be numerous needle marks and a scab which was approximately three inches below the crook of the elbow" on the defendant's left arm. The officer also testified that the defendant had admitted to the "occasional use of narcotics."

Another officer testified that he had observed essentially the same things, and that in his expert opinion (based upon more than ten years of experience as a member of the Narcotic Division of the Los Angeles Police Department) these marks and discoloration were the "result of the injection of hypodermic needles into the tissue or into the vein that were not sterile." He further stated that the defendant was neither under the influence of narcotics nor suffering withdrawal symptoms at the time he saw him; and that the defendant had admitted using narcotics in the past.

The trial judge instructed the jury that the California statute made it a misdemeanor for a person "either to use narcotics, or to be addicted to the use of narcotics." The judge further instructed the jury that:

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A Different View On

Should Alcoholics Be Jailed?

BY LYLE H. TRUAX
JUDGE, MUNICIPAL COURT, VANCOUVER, WASHINGTON

SHOULD lower courts have the power to send alcoholics to jail? This question is being re-examined by courts and widely discussed by concerned people. The answer will soon be given by our United States Supreme Court. In a case now pending before that court, the legality of arresting alcoholics for being drunk is questioned.

The defense argues that to arrest an alcoholic for drunkenness is in effect sending a person to jail for being ill.

As a judge who has worked with alcoholics for many years, I believe that few, if any, alcoholics are helped by serving jail sentences.

However, I feel that a jail sentence or threat of jail, when used to force an alcoholic into doing something about his problem can help.

Judges are in an excellent position to hold out a helping hand. Before them are brought a continual parade of alcoholics, many of whom are arrested for being drunk in public, drunk driving, disorderly conduct or assault.

In working with the alcoholic, the judge learns that his greatest obstacle is the person's own resistance. The alcoholic is usually blind to the harm that his drinking is doing to himself and family.

He is certain that he can stop or control his drinking whenever he really wants to do it, and there is always "somebody else" who drinks more or who has a harder time controlling his drinking.

The alcoholic is usually the last person to accept the fact that he has a serious problem.

The judge must overcome this resistance. To accomplish this, he must find ways of motivating the person into accepting his problem and into doing something about it. It is in providing motivation that the judge helps the person with a serious alcoholic problem.

Judges have at their disposal the power to force an alcoholic to do something about his problem. In a number of courts this power is being wisely used in carrying out programs that offer them help rather than punishment.

Today there is a growing number of judges who through understanding alcoholism are helping to lead alcoholics toward a sober life.

In Denver, Judge William H. Burnett holds a Court Honor Class each week where he leads alcoholics who have previously appeared in his court, in a discussion of the alcoholic and his problems.

Judge Keith Leenhouts of Royal Oak, Michigan, has developed a unique probation program that uses as its probation officers some of the community's leading citizens.

In Seattle, Judge Vernon W. Towne sends those convicted of drunk driving to a school consisting of a series of lectures presented by persons with a spe-

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cial knowledge of alcoholism.

In my own court in Vancouver, Washington, I have utilized a probation program in working with alcoholics, for a number of years.

When a person appears in court on a drinking violation and his past record gives evidence of a serious drinking problem, a jail sentence is entered on his docket, he is placed on probation for a year and released from jail.

His freedom depends upon his abiding by the three conditions of his probation. The first of these is that he shall not drink any alcohol whatsoever; the second is that he shall attend at least one Alcoholics Anonymous meeting each week; and the third condition is that he shall report once each month to a special probation court.

By using this type of probation, motivation for sobriety is imposed upon the alcoholic. The risk of a jail sentence from his use of alcohol is a negative motivation. It is sufficient to help a few abstain. This motivation is further reinforced each month when the offender reports to probation court.

Principal Motivation

The principal motivation, however, is a more positive one that comes from his weekly attendance at an A.A. meeting.

The first few times he goes to A.A. he is filled with resentment and hostility. As he becomes acquainted with the members, much of his resentment and hostility leaves. He finds in the group others having the same or more serious problems. He hears of their determination and the successes that they are having in staying sober.

Often, the person who, in the beginning, comes with deep hostility changes his attitude and becomes an active participant in the group.

A. A. fulfills a further need. Alcoholics, during years of drinking, establish many social patterns that evolve around their drinking. The bar or tavern becomes the center of their social life. Most of their friends are people that frequent the same bars or taverns.

To stop drinking means breaking with these patterns and finding new friends. Most alcoholics trying to stay sober face the problem that few, if any, of their friends are non-drinkers.

A.A. offers them new friends who are also seeking sobriety. Instead of being alone, they find a new social life that helps them in their effort to abstain.

By calling alcoholism a disease, we tend to oversimplify the problem. We assume that, as a disease, its treatment must be medically oriented. The American Medical Association has rightfully declared alcoholism to be a disease. However it is a particular type of disease that has little similarity with other types.

Medical treatment may be required in withdrawing the person from alcohol or in restoring his health after an extensive period of drinking. Antabuse, when prescribed to help resist the desire to drink, can be of great help. But the alcoholic's real problem involves his motivation to abstain as opposed to his compulsive desire to drink.

If the United States Supreme Court holds that lower courts have no power to sentence people for being drunk in public, it will handicap those judges who are trying to help the alcoholic. Their efforts to motivate the alcoholic into doing something about his condition is based upon the court's power to send him to jail if he continues to resist doing samething about his problem.

With over 5,000,000 alcoholics in our country the problem of alcoholism is a major national concern. In facing it, we must use all available means of combating it.

The lower court judges are in a position to help. It seems to me that the constructive approach is in stressing their opportunity and responsibility rather than in denying them the power upon which their ability to help is based.

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". . . that portion of the statute referring to 'addicted to use' of narcotics is based upon a condition or status . . . To be addicted to the use of narcotics is said to be a status condition and not an act. It is a continuing offense and differs from most other offenses in the fact that (it) is chronic rather than acute; that it continues after it is complete and subjects the offender to arrest at any time before he reforms. The existence of such a chronic condition may be ascertained from a single examination, if the characteristic reactions of that condition be found present."

The judge further instructed the jury that "all that the People must show is either that the defendant did use a narcotic in Los Angeles County, or that while in the City of Los Angeles he was addicted to the use of narcotics. . . ."

The defendant was found guilty by the jury. The appeal was taken to the appellate department of the Los Angeles County Superior Court which affirmed the conviction, and the matter subsequently was heard by the United States Supreme Court.

The Supreme Court in the Robinson case, in holding that it is unconstitutional for the state to make narcotic addiction a crime, stated (at p. 664):

"The broad power of a state to regulate narcotic drugs traffic within its borders is not here in issue. More than forty years ago, in **Whipple v. Martinson,** . . . ., this Court explicitly recognized the validity of that power: 'There can be no question of the authority of the state in the exercise of its police power to regulate the administration, sale, prescription and use of dangerous and habit-forming drugs. . . . The right to exercise this power is so manifest in the interest of the public health and welfare, that it is unnecessary to enter upon a discussion of it beyond saying that it is too firmly established to be successfully called in question.'

"Such regulation, it can be assumed, could take a variety of valid forms. A state might impose criminal sanctions, for example, against the unauthorized manufacture, prescription, sale, purchase, or possession of narcotics within its borders.

"In the interest of discouraging the violation of such laws, or in the interest of the general health or welfare of its inhabitants, a state might establish a program of compulsory treatment for those addicted to narcotics.

"Such a program of treatment might require periods of involuntary confinement; and penal sanctions might be imposed for failure to comply with established compulsory treatment procedures. (Cf. **Jacobson v. Massachusetts,** 197 U. S. 11.)

"Or a state might choose to attack the evils of narcotics traffic on broader fronts also—through public health education, for example, or by efforts to ameliorate the economic and social conditions under which those evils might be thought to flourish.

"In short, the range of valid choice which a state might make in this area is undoubtedly a wide one, and the wisdom of any particular choice within the allowable spectrum is not for us to decide.

"Upon that premise we turn to the California law in issue here.

"It would be possible to construe the statute under which the appellant was convicted as one which is operative only upon proof of the actual use of narcotics within the state's jurisdiction. But the California courts have not so construed this law.

"Although there was evidence in the present case that the appellant had used narcotics in Los Angeles, the jury were instructed that they could convict him even if they disbelieved that evidence. The appellant could be convicted, they

were told, if they found simply that the appellant's 'status' or 'chronic condition' was that of being 'addicted to the use of narcotics.' And it is impossible to know from the jury's verdict that the defendant was not convicted upon precisely such a finding. . . .

"This statute, therefore, is not one which punishes a person for the use of narcotics, for their purchase, sale or possession, or for antisocial or disorderly behavior resulting from their administration. It is not a law which even purports to provide or require medical treatment. Rather, we deal with a statute which makes the 'status' of narcotic addiction a criminal offense, for which the offender may be prosecuted 'at any time before he reforms.'

"California has said that a person can be continuously guilty of this offense, whether or not he has ever used or possessed any narcotics within the state, and whether or not he has been guilty of any antisocial behavior there.

"It is unlikely that any state at this moment in history would attempt to make it a criminal offense for a person to be mentally ill, or a leper, or to be afflicted with a venereal disease.

"A state might determine that the general health and welfare require that the victims of these and other human afflictions be dealt with by compulsory treatment, involving quarantine, confinement, or sequestration. But, in the light of contemporary human knowledge, a law which made a criminal offense of such a disease would doubtless be universally thought to be an infliction of cruel and unusual punishment in violation of the Eighth and Fourteenth Amendments. See **Francis v. Resweber,** 329 U.S. 459.

"We cannot but consider the statute before us as of the same category. In this court counsel for the state recognized that narcotic addiction is an illness. Indeed, it is apparently an illness which may be contracted innocently or involuntarily.

"We hold that a state law which imprisons a person thus afflicted as a criminal, even though he has never touched any narcotic drug within the state or been guilty of any irregular behavior there, inflicts a cruel and unusual punishment in violation of the Fourteenth Amendment.

"To be sure, imprisonment for ninety days is not, in the abstract, a punishment which is either cruel or unusual. But the question cannot be considered in the abstract. Even one day in prison would be a cruel and unusual punishment for the 'crime' of having a common cold.

"We are not unmindful that the vicious evils of the narcotics traffic have occasioned the grave concern of government. There are, as we have said, countless fronts on which those evils may be legitimately attacked. We deal in this case only with an individual provision of a particularized local law as it has so far been interpreted by the California courts."

The court in reaching its conclusion pointed out by footnotes that California had already apparently started a compulsory treatment program for persons addicted to narcotics, but the Court noted that the record before it contained no explanation as to why the civil procedures authorized by the statute were not utilized in the particular case.

The court also noted that the State of California in its brief had stated: "Of course it is generally conceded that a narcotic addict, particularly one addicted to the use of heroin, is in a state of mental and physical illness. So is an alcoholic."

Mr. Justice Douglas, in a concurring opinion, further emphasized the "cruel and unusual" punishment aspect of the Eighth Amendment in treating as a criminal a person who is a drug addict.

Mr. Justice Harlan, in a concurring opinion, did not totally agree with the majority conclusion, but did concede that under the trial court's instructions, a jury could find the defendant guilty for merely being an addict; and conceded that

under this construction, the state could authorize criminal punishment for a "bare desire to commit a criminal act."

He further stated that if the California statute reached that type of conduct, "it is an arbitrary imposition which exceeds the power that a State may exercise in enacting its criminal law. Accordingly, I agree that the application of the California statute was unconstitutional in this case and join the judgment of reversal."

Mr. Justice Clark dissented, stating that he did not consider the California statute violative of due process as a "cruel and unusual punishment."

He stated, however, that "there was no suggestion that the term 'narcotic addict' . . . included a person who acted without volition or who had lost the power of self-control," observing further that the penal provisions were "quite similar to those for civil commitment and treatment of addicts who have lost the power of self-control."

Mr. Justic White dissented, stating that "if appellant's conviction rested upon sheer status, condition or illness or if he was convicted for being an addict who had lost power of self-control, I would have other thoughts about this case . . ."

It appears, then, that even the dissenting judges would have considered the Robinson case more appropriately reversible for violation of constitutional guarantees of due process if the conviction under the statute had been based solely upon non-volitional use of narcotics.

All of the opinions in this case tend to suggest that in a similar case of non-volitional addiction, such as, for example,

addictive use of alcoholic beverages, the court would probably rule that it would be unconstitutional for a governmental authority to punish a person who is convicted of a criminal offense due solely to his use of an alcoholic beverage as a result of his addiction.

The American Civil Liberties Union, along with the Washington Area Council on Alcoholism, has taken the first known step to bring to the attention of the United States Supreme Court a "test case" involving a conviction for public drunkenness where the defendant is an addictive drinker.

DeWitt Easter, age 59, is a skilled plasterer living in Washington, D. C. His father was an alcoholic and he is an alcoholic; and he has been arrested 70 times for public intoxication since 1937. His latest conviction in the Court of General Sessions in the District of Columbia resulted in a 90-day jail term suspended.

The Easter case, which gained nationwide attention when reported in the November 27, 1964 issue of Time Magazine, was affirmed by the District of Columbia Court of Appeals which stated as follows:

"Voluntary drunkenness does not excuse crime, nor does our law recognize . . . what is called dipsomania, or distinguish between an irresistible impulse for intoxicating drinks and a mere inordinate appetite for them, brought on by long and continual indulgence."

While the Court recognized that there are not adequate and sufficient facilities for treatment of alcoholics in the District of Columbia, it nevertheless stated that Easter "was not punished because of his addiction to alcohol. He was convicted for being intoxicated in public. Any person, whether an alcoholic or not who is drunk in any public place . . . is subject to the same penalty."

If the Supreme Court hears the matter, it is at least predictable, based upon an analogy to **Robinson v. California,** that the Supreme Court would similarly rule that it is cruel and unusual punishment to jail a person for pubilc intoxication when that intoxication is due to non-volitional addictive drinking.

The American Civil Liberties Union is also assisting in a similar case in California.

Thomas Francis Budd, a 55-year-old resident of Oakland, California, was arrested on November 23, 1964, and charged with being drunk in a public place and in such a condition that he was unable to care for his own safety or the safety of others.

Our information is that the American Civil Liberties Union and other interested agencies in the California area intend to follow the Budd case to the United States Supreme Court in an effort to get a definitive determination by the Supreme Court on the constitutional issues involved in the punishment of alcoholics for the crime of public drunkenness.

We have been informed also by the Washington State Chapter of the American Civil Liberties Union that that group anticipates "bringing one or more such cases in this state (of Washington) in the near future."

A ruling by the highest court of a state or by the Supreme Court of the United States that a chronic alcoholic cannot be punished for public drunkenness would have a serious effect on the future handling of criminal cases of public drunkenness where the defendant can prove that he is an alcoholic by medical-psychiatric definition.

Necessarily, this means that courts and public agencies should put into operation, even before such a ruling is made, facilities and procedures which would permit the proper treatment of chronic alcoholics as ill persons before panic is created in our communities.

Most city ordinances relating to public drunkenness are simply of the disorderly conduct variety (For example, "It shall be unlawful for any person to be guilty of

. . . drunkenness . . ." See Seattle City Ordinance 16046, 1). There are variations of state laws relating to drunkenness. In all cases, however, the offense is punishable by fine and/or imprisonment.

If the Supreme Court rules, as we expect it will, that alcoholism is an illness and not a crime, and that a person may not be criminally punished for drunkenness due to addictive drinking, it would not mean that police officers could no longer make arrests in such cases. Nor would it necessarily mean that the courts could not bring such persons before it for processing. I envision a procedure such as this:

1. A police officer makes an arrest of a person for public intoxication.

a. The person then will be examined by a physician (at the jail or at any designated medical facility) and a case history taken. A preliminary medical opinion is given as to whether he is an alcoholic.

2. The person then appears in court for arraignment, at which time he may plead "Not Guilty," "Guilty," or "Not Guilty by Reason of Chronic Alcoholism." (The latter may take the form of a constitutional defense.)

a. If he can prove he is an alcoholic, upon conviction he cannot be given a jail sentence or assessed a fine. However, he may be further processed by the court for treatment and/or rehabilitation either compulsory or voluntary.

3. This procedure would not apply in any case other than public drunkenness; the plea of "Not Guilty by Reason of Chronic Alcoholism" would not be available for any other criminal offense.

Whether the Supreme Court rules within six months or within six years, we must now adopt laws and procedures which are compatible with advanced medical findings: that alcoholism is a disease and not a crime and that alcoholics who become intoxicated in public should be treated as ill persons and not as criminals.

THE SOMA & THE PSYCHE

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largely colored by the attitude prevalent in society rather than by basic social and medical research. Until the entire attitude of our society can be changed in regard to alcohol and alcoholism, the doctor and his family will be victimized as will all other families when this illness strikes. This is why the physician's social and moral attitude toward alcoholism is far more important than his medicine in the overall solution of the illness. In the basic treatment of alcoholism, physicians are members of society first and doctors second.

In closing may I state that I am aware of the frustration the alcoholic causes you and I can give you the reason for that frustration and consequent hostility toward the relapsing patient. You feel that the patient is taking advantage of you and this is true. The only way to avoid frustration and resentment is to refuse to be exploited. As regards alcoholism this can be done in one of two ways: by refusing to treat alcoholics or to treat the entire family and begin any treatment of an alcoholic with this arrangement with the family. One doctor can not do this alone, but it could be achieved if the medical profession had a standard medical procedure and treatment of the family was standard medical practice.

Finally I must be quite honest and make one obvious statement. If the psyche of the alcoholic is treated early enough, the somatic treatment of alcoholism will not need your care. If the churches and the schools were competent in their approach, I would be out of a job and you would have few patients suffering from chronic and acute alcoholism.

• *Recommended is a short-term program to develop and prompt motivation.*

Motivation vs Rehabilitation—In the Local Jail

BY ASHTON BRISOLARA, M. Ed.
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AND
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REHABILITATION has long been emphasized as the solution to our jailed alcoholic problem. Success of such a program implies a prisoner's willingness or motivation to be assisted, and an adequate period of time during which inmates can actively participate in the program. The ideal setting for such work is a penitentiary or similar penal institution where prisoners are committed for extensive periods of time. Even in such ideal situations, the success will ultimately rest on the degree of motivation prevalent in the individual inmate. Despite the fact that studies indicate that enforced rehabilitation or treatment is productive, personal willingness or acceptance is imperative—at least to some degree.

There are therapists who claim that all motivation is basically enforced, either by outside prompting or ultimatum, or by personal discomfort. Therapy induces motivation where absent, and increases it, where present, they claim. But again, the inmate, or anyone for that matter, cannot be forced to adjust. Adjustment or rehabilitation is limited only by individual capacities and the degree of motivation. No one can deny that attitude and time play important roles in the rehabilitation process.

How does the local jail qualify as the setting for a continuing rehabilitation program?

Most, if not all, city jails are for short-term sentences for a multitude of municipal offenses. On the basis of "length of sentence," a rehabilitation program would be faced with a revolving door experience of either new faces or the recidivist, whose program of rehabilitation would be a one-time experience or interrupted by periods of "freedom" from supervision and therapy. Continuity would be most difficult, if not impossible.

Let us emphasize that we speak here of the local municipal jail or house of detention setting.

Rehabilitation signifies a total rebuilding, implying the total man—body, mind and soul. None of these areas should be neglected while the individual is in prison but, faced with such diversified problems, a comprehensive rehabilitation program as such in a jail would not only be impractical, but outside of the financial scope of most communities.

An evaluation of local jails would seem to indicate that the prognosis for success of a rehabilitation program in such a setting would be dubious. It would be more valuable

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A CRITICAL REVIEW

BY SELDON D. BACON, Ph.D.

State Program on Alcoholism

Being concerned with alcoholism and with the recovery of individual alcoholics are worthwhile but different goals.

THE goals of alcoholism organizations do not seem to be concerned directly or even in large part with alcoholism. Rather, they seem to be concerned with the recovery of individual alcoholics. These are quite different goals requiring different allocations of resources, presenting different problems, and offering different effects. Both goals are entirely laudable and this review does not apply to one or the other, but to the recognition of the differences. I feel the two goals can be compatible. However, I am undoubtedly prejudiced in favor of the attack on alcoholism as being a greater goal than caring for individual alcoholics.

When I state that the goal of alcoholism programs is primarily couched in terms of care and treatment for the alcoholic, I am basing the claim not on what these organizations say, but what they do. Particularly I think of their allocation of resources. With possibly two or three exceptions, the lion's share is placed in the field of treatment. Perhaps 90 per cent of the funds for the majority of programs, aside from direct administrative costs, are devoted to this purpose.

Looking at another facet of alcoholism programs, that of education, one could again expect to find that perhaps 90 per cent of the education and training activities deal with treatment and care. These may be concerned with treatment techniques, availability of treatment facilities, or motivation of alcoholics to seek treatment.

A third activity engaged in by many alcoholism programs is research. Here again I would submit that perhaps 90 per cent of the research activity is focused on treatment, extension of treatment, treatment procedures, success of treatment, failure of treatment, dangerous treatment, treatment histories, etc.

All of these treatment oriented activities focus not on alcoholics, but on alcoholic patients. These patients form far less than 10 per cent of the population of alcoholics and are almost certainly not representative of that population.

After having stated that most alco-

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holism program activity centers around treatment, I would like to raise questions about the end results to be expected from a reasonable or high-level success in the pursuit of the individual treatment goal. First, is such success in treating an alcoholic a worthwhile accomplishment from the standpoint of usual value judgments in our society? The answer is yes; effective treatment for an alcoholic is a challenging and worthwhile goal.

Important Question

But is not treating a population of alcoholics through time with reasonable success also a worthwhile goal? I would answer that it is an enormous worthwhile goal and that it is achievable. The other goal, that of helping the individual alcoholic, is included in this new, broader goal.

Now for the important question: Can the goal of helping alcoholics through time in a given area by a governmental program be accomplished by the dominant means currently used by most of them, i.e., providing treatment for alcoholics? I doubt this very much. It is my personal opinion that over a period of 20 years it would require eight times our present supply of treatment resources for alcoholics just to catch up with the number of new alcoholics each year.

Why then, among alcoholism programs, has there been such an enormous emphasis upon providing treatment services?

First, it became surprisingly apparent that alcoholics could recover. A growing number of these cases provided the impact necessary to sweep the entrenched, prestigeful and negative powers aside and allow a new idea and a new technique to find a place in the sun.

The second fact was the need felt by relatives and friends of alcoholics. They were not interested in alcoholism or alcoholics; they were interested only in their particular alcoholic. They did not care about public health rates or statistical columns or logical probabilities. They wanted to see the miracle in their own alcoholic. Here again the individual recovered alcoholic was the tool by which the unorganized public could bring pressure on the organized groups in the professions, in the field of communication, and in government.

Third, in competing for resources with which to operate, alcoholism programs themselves have exhibited the recovered alcoholic as their defense against budget cuts and as their justification for expansion. If one could show that in the past six months he had helped 10 or 20 alcoholics, so it followed that, if he had twice the resources he could help 35, 40 or perhaps 50 alcoholics in the next six months.

Another fact to be considered is the personal reward that lies in the therapeutic relationship. Therapists, secretaries, board members—everyone connected with alcoholism programs—feels involved in the treatment of the patient. The feeling of accomplishment here and now is much more definite and satisfying than doing something for a population of alcoholics "out there," or helping alcoholics in general five years from now.

If the full resources of alcoholism programs cannot handle even one-eighth of the treatment cases which must be seen if treatment for alcoholics through time in a socio-cultural area is to have a chance of success, then the suggestion that they reduce even the amount of resources devoted to treatment at present must indicate either that treatment of the individual alcoholic is

unimportant or that there are other sources of treatment activity.

I feel that treatment personnel is potentially available. The training of 25 social workers or 25 physicians or 25 volunteers, training in the best sense of the word, can result in more treatment service for alcoholics through time in a given area than can be gained by the actual treatment process in terms of exactly the same amount of resource expenditure over the same period of time by any one alcoholism organization. Yes, there are problems involved in accomplishing this, and I'm not advocating that any alcoholism program give up its treatment services. I'm merely pointing out an alternative that can challenge the imagination and possibly offer far-reaching results.

Work With Other Disciplines

If we are going to work with alcoholics through time in a sociocultural area we are going to have to work with other disciplines, other groups, and other problems. This is a difficult and dangerous task. "Joining" does not imply loss of identity or significance or activity. Quite the contrary, it means an enhancement of these; otherwise it means strangulation.

This will be difficult. But don't forget this. Other organizations and professionals may carry a tremendous load of frustration, cost, bad public relations, etc., because of alcoholism. We have ways to soften that load, ways to bring a reduction of those pains. I do not mean that we should be telling these people about alcoholism and about how wonderful we are and how we could solve their problems and implying that they are wrongheaded, incompetent and somewhat immoral. Quite to the contrary, we have to learn from them what their related problems are, stated in their language, not ours. We have to find out their relevant goals, which by definition will not be ours. And we must discover what we may have that might be of practical use to them.

This means public health; it means study; it means communication. One of the first things it means is that we should know far more about the alcoholisms, far more than treatment for *our* choice of alcoholic patients for *our* programs. It means also that we must develop new languages and new means of communication. And we, not they, will have to take the initiative.

If this assessment of goals is at all cogent, we must ask if anything could be done about it? I think the answer is "yes" and I think this is the place and this is the time and right in this room are the people to do something.

The first step should be a searching of the reality and relevance of the assessment here proposed. If it has reality and relevance, then strategy and tactics and allies and timing and location and varied allocations of resources can be proposed, tried out, revised and so on.

The major suggestion arising from this review would seem to be a reassessment of the situation, a hard look at the goals of the alcoholism programs as they are expressed in allocation of resources, and a determination not to consider the past 18 years as a final victory. It has been a tremendous 18 years. There has been great progress. At least one great wall (the belief that alcoholics are untreatable) is crumbling before us. Let us be very sure that we capitalize on this progress and that we take the most effective next steps in continuing the attack on the alcoholisms.

WE cannot afford to defer action to solve alcoholism problems simply because it is not easy to define what we mean by "alcoholism" or because there is no conclusive evidence as to its causes.

Alcoholism, recognized as one of our major medical-social problems, is complex and challenging. But, the U. S. Department of Health, Education, and Welfare (HEW) is determined to take a vigorous and creative role in meeting this challenge.

Alcoholism programs, although operating under many handicaps, have been a major force in demonstrating that effective treatment and rehabilitation of alcoholics can be provided by professionals trained in medical and social disciplines. Of equal importance, these programs have contributed immeasurably to the creation of an atmosphere and structure on which to build and move forward at an accelerated pace.

They have put into practice and demonstrated conclusively that alcoholism services should be comprehensive; that all community agencies can and should relate to them in daily activities; and that existing resources are available and can be organized to provide a continuum of comprehensive care.

Perhaps most important of all, alcoholism programs have been a source of hope in an area where hope is a precious and vital need. By applying known techniques to action programs, and not waiting for final or complete answers, creative steps have been taken in a field that for too long has been neglected.

I am convinced of the need to move forward with expanding programs on all levels. In order to establish the point from which we must begin, let us examine the present Federal approach and what has already been accomplished.

This article is based on an address, presented at the annual meeting of the North American Association of Alcoholism Programs, Atlantic City, N. J., September 22, 1965, as it was condensed and published in *Lifelines,* educational journal of the South Carolina Alcoholic Center. The author, Dr. Lee, is deputy assistant secretary, U. S. Department of Health, Education, and Welfare, and is chairman of the Secretary's Committee on Alcoholism.

BATTLE PLANS

Within HEW, the Public Health Service's National Institute of Mental Health is the focal point for alcoholism. The institute has provided a broad base for expanding activities and meeting immediate needs.

There has been a series of actions taken by the department. Among them, the first National Conference on Alcoholism ever called by a HEW Secretary was a major milestone. Following the conference, work was begun by the American Public Health Association, under an NIMH grant aimed at developing a guide for public health control of alcoholism.

The Honorable Wilbur Cohen, Under Secretary of HEW, presented the first major paper on alcoholism activities of the department.

The Public Health Service's Division of Community Health Services was assigned responsibility for developing and proposing a program on alcoholism to deal with the public health aspects. The Welfare Administration announced that it may participate in providing services to families whose social and economic conditions contribute to alcoholism.

Smithers Hall, housing the Center of Alcohol Studies at Rutgers University was dedicated. It was financ-

HEW's plans are structured to assist those responsible for prevention and control of alcoholism in state and local communities.

BY PHILIP R. LEE, M.D.

FOR A NATIONAL ATTACK

ed in part by an NIMH grant.

The Vocational Rehabilitation Administration convened the first National Conference on "Alcoholism and Vocational Rehabilitation."

The "Conference on the Court and the Chronic Inebriate" was sponsored by the HEW Secretary's Committee on Alcoholism, and this was followed by the "Conference on Alcohol and Accidental Injury."

The "First National Conference on Legal Issues in Alcoholism and Alcohol Usage" was supported by the NIMH.

These are only some of the significant outgrowths of the First National Conference on Alcoholism.

Other beginnings are evident in proposals which the President has submitted to the Congress and in his continuing concern for the well being of all our people.

Many Congressmen have commented about the problems of alcoholism. Congressman Oren Harris, chairman of the House Committee on Interstate and Foreign Commerce, said, "We have a problem with alcoholism. I intend to schedule some hearings on the subject . . . as soon as the program of the committee will permit." (Editor's note: Indicating the interest being generated in Congress, these hearings were announced during the NAAAP meeting and were held the following week.)

A brief rundown of this year's legislation includes: medicare; the elementary and secondary school act; the mental retardation facilities and community mental health centers construction programs amendments; the health research facilities act; expanded social security; and the proposed program to establish medical complexes to deal more forcefully with heart disease, cancer, and stroke.

Congressional reaction to these proposals submitted by the President, as well as the creation of new programs, has important and relevant application to the problems of alcoholism. It reflects a real consensus, evolving over more than 30 years, which the President has been able to effectively mobilize in his legislative program.

All those who have worked together to combat alcoholism problems have helped to develop a constructive accord regarding alcoholism. This is reflected in the many letters received at the White House, in letters and telephone calls received

by Congress and by HEW, and the increased interest of professional groups and the public. An atmosphere has been provided for a more creative, courageous and spirited attack on the problem.

Guidelines for the kinds of action to be taken are being made available from many sources. The Cooperative Commission on the Study of Alcoholism is scheduled to complete its work this year and will provide invaluable information on which to further develop programs. The Secretary's Committee on Alcoholism is another source in new program planning.

The position statement of the North American Association of Alcoholism Programs was presented to and discussed by its Executive Secretary with Under Secretary Cohen. For new and expanding program development this statement will be most helpful, particularly as it reflects the consensus of the official agencies who are in daily contact with alcoholism problems.

Other agencies have increasingly related their skills and experiences, as well as their resources, to alcoholism problems.

Nevertheless, more must be done.

The question arises: What is HEW planning?

In answer, we hope to see a rapid expansion and strengthening of resources to mount an attack commensurate with the importance of alcoholism problems. Our plans are structured to assist those responsible for prevention and control of alcoholism in our state and local communities.

There is specific need to expand the department's current alcoholism activities by:

1. Improving coordination of the alcoholism activities of the department's constituent agencies.

2. Fostering closer relationships and improved communication between the department and other groups interested in this medical-social problem.

3. Extending and intensifying alcoholism research.

4. Extending and intensifying a broadbased national alcohol education program for professional and lay audiences.

5. Enabling communities to coordinate and utilize existing resources into a unified, comprehensive service.

6. Creating a national action policy based upon an awareness that alcoholism is potentially a treatable and preventable medical-social problem, and aimed at encouraging hospitals, clinics and centers to admit and treat routinely patients with alcoholism problems; physicians to treat, counsel, and refer alcoholics; public and private health, education, and welfare agencies to institute policies and procedures that would provide services within the framework of their functions and responsibilities; and government, as a major employer, to recognize alcoholism as a medical, mental health, and personnel problem, and to include it in employee health programs.

How and by whom a new and expanded program for alcoholism control would be administered is another question. We in the Department of Health, Education and Welfare would develop and propose to work this out with experienced and interested members of Congress, who have a major role and responsibility to help us solve some of the many problems facing us in the field of alcoholism.

It is only with the continued help of those who have led the way in this critical area that action initiated in this decade can exploit the new breakthrough and bring about the ultimate prevention and control of alcoholism in our society.

CONTINUE DFROM PAGE 24

and economical to exert efforts towards motivation with all of its far-reaching implications.

Motivation from the penal viewpoint is the desire to be rehabilitated—helped, educated, trained, resocialized, treated, spiritualized, etc. In essence it is the desire to be physically, spiritually, and emotionally mature within the scope of individual capacities. Restated, it is a yearning to reach one's full potential status as a man.

While participation in rehabilitation programs can be prompted by ulterior motives — shortened sentences, parole, freedom within the prison, etc. — motivation in itself precludes any immediate rewards. It implies self-determination and active participation on one's own after release from jail.

The desire to be free—to stay free—to be a man among men can provide the foundation of rehabilitation. The primary concern of jailers or wardens should be the development of motivation within the confines of the jail.

Such a program would include two phases:

1. *An ongoing program, including lectures, talks, recordings, films, meetings, group sessions—all geared to education, information, and a prompting of motivation.*

This necessitates a thorough evaluation of the prison population, including educational standards and backgrounds, religion, medical history, occupational status, commitment records, etc. Such an analysis would probably be best accomplished through a recording system with at least an adequate sampling, perhaps taken for a period of 9 to 12 months. Only when understanding of the inmate population is obtained can proper incentives be placed before the group. This statistical study will assist in the formulation of the beneficial procedures outlined in phase number one.

2. *A system of referral within the jail and extended to the "outside" must be implemented.*

Since the alleviation and solving of problems as well as the amassing and development of skills and knowledge through therapy and training prerequisites a *team approach* to a multitude of human needs, a comprehensive referral system must be inaugurated, utilizing every possible community resource. Liaison must be maintained with these agencies, and prisoners inculcated with the realization that the community as well as prison officials are interested in their welfare.

Such a referral system is *economical,* utilizing existing facilities at no extra cost to the community. It is *professional,* employing experts who deal with problems in their specific field of interest. It is *humane,* eventually releasing the prisoner on a personal and sympathetic note.

Unfortunately, the jail has become a haven for not only criminals, who must fulfill the demands of justice, but for a variety of social, psychiatric, and health problems which belong, by nature of the problem, in a hospital or medical center or clinic. The alcoholic falls in this category of sick persons who need, before all else, medical attention and therapy.

Since the municipal jail is not the best setting for a full-scale rehabilitation program, the next best approach, it would seem, is a short-term program to develop and prompt motivation.

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ASHEVILLE—

**Alcohol Information Center;* Mike Dechman, Educational Director; Parkway Offices; Phone: 704-252-8748.

†*Mental Health Center of Western North Carolina, Inc.;* 415 City Hall; Phone: ALpine 4-2311.

BURLINGTON—

**Alamance County Council on Alcoholism;* Margaret Brothers, Executive Director; Room 802, N. C. National Bank Building; Phone: 919-228-7053.

‡*Outpatient Clinic;* Alamance County Hospital; Hours: Wed., 9:00 a.m. - 4:00 p.m.

BUTNER—

‡*Aftercare Clinic;* John Umstead Hospital; Hours: Mon. - Fri., 9:00 a.m. - 4:00 p.m.

CHAPEL HILL—

†*Alcoholism Clinic of the Psychiatric Outpatient Service;* N. C. Memorial Hospital; Phone: 942-4131, Ext. 336.

**Orange County Council on Alcoholism;* Calvin Burch, Box 277, Carrboro; Phone: 919-942-1089 or (if no answer) 919-942-1930.

CHARLOTTE—

**Charlotte Council on Alcoholism;* Rev. Joseph Kellermann, Director; 1125 E. Morehead St.; Phone: 704-375-5521.

‡*Mecklenburg Aftercare Clinic;* 1200 Blythe Blvd.; Hours: Mon. - Fri., 8:00 a.m. - 5:00 p.m.

†*Mental Health Center of Charlotte and Mecklenburg County, Inc.;* 316 E. Morehead St.; Phone: 704-334-2834.

CONCORD—

†*Cabarrus County Health Department;* Phone: STate 2-4121.

DURHAM—

‡*Aftercare Clinic;* Watts Hospital; Hours: Tues. and Fri., 2:00 - 5:00 p.m.

**Durham Council on Alcoholism;* Mrs. Olga Davis, Executive Director; 602 Snow Bldg.; 919-682-5227.

FAYETTEVILLE—

†*Cumberland County Guidance Center;* Cape Fear Valley Hospital; Phone: HUdson 4-8123.

GASTONIA—

†*Gaston County Health Department;* Phone: UNiversity 4-4331.

GOLDSBORO—

‡*Outpatient Clinic;* Cherry Hospital; Hours: Tues. and Fri., 10:00 a.m. - 12:00 noon. Thurs., 2:00 - 4:00 p.m.

**Wayne Council on Alcoholism;* H. B. Hulse, Executive Director; P. O. Box 1598. Phone: 919-735-7033.

GREENSBORO—

**Greensboro Council on Alcoholism;* Worth Williams, Executive Director; 216 W. Market St., Room 206 Irvin Arcade; Phone: 919-275-6471.

†*Guilford County Mental Health Center;* 300 E. Northwood St.; Phone: BRoadway 3-9426.

†*Family Service Agency;* 1301 N. Elm St.

‡*Outpatient Clinic;* 300 E. Northwood St.; Hours: Mon. and Thurs., 5:00-10:00 p.m.

GREENVILLE—

**Pitt County Alcohol Information and Service Center;* Helen J. Barrett, Executive Secretary; P. O. Box 2371; 915 Dickinson Ave.; Phone: 919-758-4321.

†*Pitt County Mental Health Clinic;* Pitt County Health Department, P. O. Box 584; Phone: PLaza 2-7151.

HENDERSON—

**Vance County Program on Alcoholism;* Dr. J. N. Needham, Director; 2035 Raleigh Rd.; Phone: 919-438-3274 or 919-438-4702.

HENDERSONVILLE—

Alcohol Information Center; S. Robertson Cathey, Director; 2nd Floor, City Hall; Phone: 919-692-8118.

HIGH POINT—

†*Guilford County Mental Health Center;* 936 Mountlieu Ave.; Phone: 888-9929.

JAMESTOWN—

**Alcohol Education Center;* Ben Garner, Director; P. O. Box 348; Phone: 919-883-2794.

LAURINBURG—

**Scotland County Citizens Council on Alcoholism;* M. L. Walters, Executive Secretary; 308 State Bank Bldg.; P. O. Box 1229; Phone: 919-276-2209.

MORGANTON—

‡*Aftercare Clinic;* Broughton Hospital; Hours: Mon.-Fri., 2:00-4:00 p.m.

NEW BERN—

**Craven County Council on Alcoholism;* Gray Wheeler, Executive Secretary; 411 Craven St., P. O. Box 1466; Phone: 919-637-5719.

**†Psychiatric Social Service,* Craven County Hospital; Phone: 919-638-5173, Ext. 294; Hours: Mon.-Fri., 9:00 a.m.-5:00 p.m.

NEWTON—

**Educational Division, Catawba County ABC Board;* Rev. R. P. Sieving, Director; 130 Pinehurst Lane; Phone: 704-464-3400.

NORTH WILKESBORO

Wilkes County Council on Alcoholism; William S. Call, Executive Director; Old Elementary School Bldg.; Phone: 919-838-6046.

PINEHURST—

Sandhills Mental Health Clinic; Box 1098; Phone: 295-5661.

RALEIGH—

‡*Aftercare Clinic;* Dorothea Dix Hospital, S. Boylan Ave.; Phone TEmple 2-7581; Hours: Mon.-Fri., 1:00-4:00 p.m.

†*Outpatient Clinic of the Mental Health Center of Raleigh and Wake County, Inc.;* Wake Memorial Hospital; Phone: 834-6484; Hours: Mon.-Fri.; 8:30 a.m.-5:30 p.m.

SALISBURY—

**Educational Division, Rowan County ABC Board;* Peter Cooper, Director; P. O. Box 114; Phone: 919-633-1641.

†*Rowan County Mental Health Clinic;* Community Bldg., Main and Council Sts.; Phone: MElrose 3-3616.

SANFORD—

†*Mental Health Clinic of Sanford and Lee County, Inc.;* 106 W. Main St.; P. O. Box 2428; Phone: 775-4129 or 755-4130.

SHELBY—

†*Cleveland County Mental Health Clinic;* 101 Brookhill Rd.; Phone: 482-3801.

SOUTHERN PINES—

**Moore County Alcoholism Program;* Rev. Martin Caldwell, Director; P. O. Box 1098; Phone: 919-692-6631.

WADESBORO—

**Education Division, Board of Alcohol Control;* Robert M. Kendall, Director; 125 W. Wade St.; P. O. Box 29; Phone: 704-694-2711.

WILMINGTON—

**Mental Health Center of New Hanover County;* 920 S. 17th St.; Phone: 763-7342.

**New Hanover County Council on Alcoholism;* Mrs. Margaret Davis, Executive Secretary; 211 N. Second St.; P. O. Box 1435; Phone: 919-736-7732.

WILSON—

‡*Aftercare Clinic;* Encas Station; Hours: Mon.-Fri., 8:00 a.m.-5:00 p.m.

†*Wilson County Mental Health Clinic;* Encas Rural Station; Phone: 237-2239.

WINSTON-SALEM—

**†Alcoholism Program of Forsyth County;* Marshall C. Abee, Executive Director; 802 O'Hanlon Bldg., 105 W. 4th St.; Phone: 919-725-5359.

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